

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
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Washington, D.C.

Thursday, April 12, 2001
10:27 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
AUTRY O.V. DeBUSK
GLENN M. HACKBARTH
FLOYD D. LOOP, M.D.
ALAN R. NELSON, M.D.
JANET G. NEWPORT
CAROL RAPHAEL
ROBERT D. REISCHAUER, Ph.D.
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

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1 about what's the reality of trying to classify all this
2 stuff.

3 DR. WILENSKY: Okay, thank you. Commissioners who
4 have individual comments to suggest to Julian on this
5 chapter, please contact him and give him your comments on
6 your written chapter drafts

Agenda item: Quality Mary? We know you're here without your co-
8 authors, one of whom is imminently waiting to hatch, we
9 understand.

10 DR. MAZANEC: It's very lonely at this table
11 today.

12 We have significantly revised the chapter on
13 quality of care to reflect the Commission's comments at the
14 March meeting. We tried to refocus the chapter to emphasize
15 the needs of the beneficiary.

16 Medicare's primary goal is to ensure that its
17 beneficiaries have access to medically necessary care of
18 high quality. Recent evidence suggests that the provision
19 of necessary ambulatory care is roughly comparable between
20 rural and urban beneficiaries.

1 Although differences in the receipt of necessary
2 care appear to be modest, beneficiaries residing in remote
3 rural areas, including HPSAs, are less likely to receive
4 necessary ambulatory care compared with beneficiaries
5 residing elsewhere.

6 While the delivery of necessary ambulatory care to
7 rural beneficiaries appears to be roughly comparable to
8 urban beneficiaries, differences exist in the clinical
9 outcomes of beneficiaries who receive care from small
10 inpatient providers located both in rural and urban areas,
11 as compared with larger providers.

12 In your mailing materials, we also reviewed
13 beneficiary satisfaction with care. In general, rural
14 beneficiaries report being satisfied with their care,
15 although they have more difficulty in actually getting to
16 sites of care.

17 Recent MedPAC analyses have demonstrated that
18 opportunities exist to improve the quality of care furnished
19 to both rural and urban beneficiaries. This may involve
20 broadening the measures of clinical performance and outcomes

1 data that are collected. Medicare should develop systems
2 that regularly monitor the quality of care furnished to
3 beneficiaries residing in rural areas.

4 Data we presented in the paper suggests continued
5 need for quality improvement efforts to improve care across
6 rural areas. Under the previous contract for the peer
7 review organizations, QI activities have improved the
8 quality of care among certain providers in rural areas. For
9 example, as noted in your mailing materials, treatment of
10 acute MI patients with aspirin or thrombolytics improved
11 following a PRO initiative.

12 This brings us to our first draft recommendation.
13 MedPAC recommends including rural populations on the list of
14 population groups that the peer review organizations must
15 consider in carrying out their quality improvement
16 activities.

17 Medicare sets participation standards for health
18 care providers to ensure a minimum standard for quality and
19 safety of care furnished to its beneficiaries. Under
20 current funding and legal requirements, most facilities are

1 surveyed relatively infrequently. In addition, rural
2 providers face fewer incentives to seek private
3 accreditation compared with their urban counterparts.

4 This leads us to the second draft recommendation.
5 MedPAC reiterates its recommendation made in June of 2000
6 that the Congress should require the Secretary to survey at
7 least one-third of each facility type annually to certify
8 compliance with the conditions of participation.

9 I'm going to stop here and open this chapter up
10 for comment.

11

12 MR. DeBUSK: The first draft recommendation,
13 MedPAC recommends that the Secretary require the peer review
14 organizations to include rural populations in the groups
15 that they consider in carrying out their quality improvement
16 activities. What does that mean?

17 DR. MAZANEC: What we wanted to do is to try to
18 encourage PROs to look at rural sites of care in some of
19 their activities, in some of their quality improvement
20 activities or studies that they have. That does not mean,

1 as stated in the chapter, that we want rural populations to
2 be designated as the equivalent of a minority group or an
3 ethnic group, but we wanted to somehow support PRO
4 activities in rural areas more than what we are currently
5 seeing.

6 MR. DeBUSK: You look at this and what is the
7 approach? That's one major area in rural facilities that I
8 think there's a lot lacking, in getting to the patient
9 faster, taking care of the patient, providing the proper
10 care, and what have you, the access, quality and all comes
11 into play right here.

12 A lot of this just seems like words. And maybe
13 that's all we can do, but it looks like there should be some
14 way that we can do more than just pass the football.

15 MR. HACKBARTH: As I recall from the chapter, the
16 problem that we're trying to address is that the current
17 scope of work has a metric that biases the PROs towards
18 focusing on high population areas. That's where their
19 rewards are.

20 Basically, we're recommending simply that the new

1 scope of work not have that bias towards high population but
2 that we specifically carve out some resources for improving
3 quality in rural areas without trying to micromanage the
4 Secretary and how they write the scope of work.

5 DR. NEWHOUSE: I'll take my prerogative as
6 temporary chair. This is actually for people to shoot at,
7 because I'm not sure how I come down on it. But in light of
8 the previous discussion of the diversity among rural areas,
9 is this potentially overly broad? Or should we point toward
10 where we think problems are more likely to be?

11 MS. NEWPORT: I was feeling the same way, Joe.
12 This may be too broad. Just based on experience in M+C,
13 where the quality measurement standards start out with four,
14 then eight. And you need to have clinically, I understand
15 from talking to my medical directors, you need to have a
16 trend that you can monitor to improvement and reasonable
17 improvement. And that the pylon at HCFA, in terms of
18 increasing the standards and 10 percent improvement per
19 year, which is impossible after a while.

20 So I would like to see this moderated in terms of

1 appropriateness, in terms of burden, two or three areas
2 recommended. Let's say diabetes control, coronary issues,
3 something like that, and build on that and have them
4 symmetrical enough or identical enough that they can be
5 implemented and then trended and then looked at in terms of
6 okay, where can we go next?

7 So while the PROs may choose to carry it out
8 slightly differently, at least the providers that are going
9 to be measured for quality will have apples to apples as
10 much as possible.

11 I think that if we kind of align ourselves around
12 something like that, it should be right sized for the size
13 of the providers in the community, so that's implementable,
14 measurable, and it has some meaning over time.

15 DR. LOOP: Picking up on that last comment, I
16 think if we want to debride some of HCFA's responsibilities,
17 we ought to let the Joint Commission assess quality.

18 But let me make a couple of points about this
19 chapter.

20 DR. ROWE: Or NCQA or somebody else.

1 DR. LOOP: Yes. The first sentence under key
2 points, that a large gap exists between the care they should
3 receive and the care they do receive, I think probably care
4 is not optimal. As you get down into deeper and deeper into
5 ruralness that's probably true.

6 But over here on page four, near the end of the
7 page, you say that remote rural areas are 2.5 percent less
8 likely to receive clinically appropriate care compared with
9 beneficiaries residing in metropolitan counties. Is that a
10 lot? Is that a little? Does that also mean metropolitan
11 counties don't get very good care either, compared to what
12 they should have?

13 I think we have to clean up some of that because
14 it sends a bad message out which is highly subjective and
15 not necessarily true, I don't believe.

16 DR. WAKEFIELD: Just a couple of comments, first
17 if I could on the chapter. I think that when this gets
18 written, if there was a way of speaking maybe a little bit
19 more to -- the chapter starts out talking about standards, I
20 think, and whether rural areas meet the same standards,

1 should they meet the same standards, et cetera, as urban
2 areas do. And how do you measure that anyway, if it's beta
3 blocker usage or whatever?

4 But I think that later in the chapter, but at
5 least as important a point, is first we need standardized
6 ways of getting information. In some instances, rural
7 hospitals are at, I think, a disadvantage for collecting
8 information. So before you set the standards, how are we
9 going to get there? What are the standardized ways we're
10 all going to agree on that will be collecting that
11 information?

12 You get into it a little bit toward the end, I
13 think, when you're talking about performance indicators, et
14 cetera. But maybe that could be beefed up, because I think
15 that is a challenge.

16 Related to that, part of that data collection
17 also, I think, speaks to the availability of things like
18 electronic medical records and other IT infrastructure, et
19 cetera. So those two issues are not completely divorced.
20 They don't have that infrastructure. It's really difficult

1 to collect standardized information on the extent to which
2 they're meeting standards.

3 So it's maybe trying to put a little bit more of
4 that spin into it because I think that's an important
5 challenge to highlight.

6 Related to the recommendation, I didn't have a
7 problem with this recommendation. I actually thought it was
8 a good one. I don't have a problem with targeting it
9 further the way perhaps that's been suggested here. So that
10 we really make sure that the PROs are providing a QI assist
11 to those rural areas that might need it the most.

12 But I would say that last time we discussed this
13 draft, and I believe it's still in here, you talk about I
14 think the disincentives to PROs to reach out to rural
15 providers. I think what we're trying to do is moderate that
16 disincentive a little bit, particularly given that we've got
17 lots of hospitals out there who are not JCAHO accredited,
18 for example, who rely on state survey and cert processes.

19 So we've got a disincentive I think we're trying
20 to moderate. And we've got probably a QI infrastructure

1 somewhere in South Dakota that doesn't look like Beth
2 Israel's QI infrastructure. So I think there's a legitimate
3 need in a lot of cases, and I think that we ought to be
4 trying to moderate a little bit that disincentive the PROs
5 are probably currently under.

6 DR. NELSON: My comments were along a similar
7 vein. Mary replied to, I think Pete's question, that draft
8 recommendation one -- and you use the word encourage, the
9 Secretary encourage the peer review organizations to include
10 rural populations.

11 I think it would be a big mistake for us to try
12 and rewrite the PROs scope of work for them. I think we
13 have to acknowledge that the Utah PRO has a different kind
14 of capability than say a PRO in a rural area in Florida
15 might have, for example.

16 I think it's entirely appropriate to recommend
17 that the Secretary encourage more attention to quality
18 assurance in the rural areas, but that can be done through
19 providing adequate funding for the PROs to do this kind of
20 thing. I would prefer to stay away from the word require

1 and substitute instead the word encourage.

2 DR. WILENSKY: We'll come back and let's have a
3 specific discussion and do a vote on the recommendation when
4 we're through with this discussion.

5 MR. HACKBARTH: I was just going to second the
6 point that Floyd had made about the use of appropriate
7 services. To me, the striking thing is that urban or rural
8 alike are only getting the appropriate services 73 percent
9 of the time. Then the differences between urban and rural
10 in that context seem quite small. Even the difference
11 between the urban and the remote rural of 2.5 percent seems
12 quite small compared to 73 percent versus 100.

13 So the news here, to me, is the similarity between
14 urban and rural and the fact that everybody is getting only
15 73 percent of what the measures say they need.

16 DR. STOWERS: I think what I wanted to say is kind
17 of echoing that too. An example of that is the bullet
18 points on page 12, where we talk about the Western states
19 having the success of raising from 40 percent to 75 percent
20 on pneumococcal, for example.

1 I think it would be very nice to demonstrate what
2 the national numbers are. Maybe not necessarily even urban
3 versus rural, but if we're going -- to kind of put that into
4 perspective. Because I couldn't agree more that the 70
5 percent to 100 percent is a lot bigger difference than maybe
6 what the difference is otherwise.

7 Because the numbers nationally on these things do
8 not look very well. And so to say that they were not very
9 good in these particular rural areas misses the point that
10 nationally they're terrible.

11 DR. REISCHAUER: We have a trade-off here really
12 between equity and efficiency. And if the differences
13 between rural and urban aren't very great, by suggesting
14 that more resources should be devoted to rural, we're
15 basically saying that overall the bang from the buck that
16 we're going to get in improving quality is probably less
17 after our recommendation than before.

18 And I think that's fine, if we think that equity
19 deserves more emphasis than it's received in the past. But
20 we're making it out as if the PROs have been greedily

1 focusing on urban areas for their own interest, as opposed
2 to by focusing there they might be affecting the quality of
3 care received by the most number of people per buck spent.

4 So it's a complicated kind of issue and I don't
5 think we should -- I think we should say a little more about
6 that trade-off.

7 DR. NEWHOUSE: I agree with Bob's last point,
8 although the right answer surely can't be to spend it all on
9 the urban areas.

10 But I was going to a different word, that I hadn't
11 really noticed until lately, which is that the peer review
12 organizations include rural populations. Don't you mean
13 rural providers? Do you mean populations or providers?
14 Insofar, for example, as the Nebraska PRO incentive is to
15 focus on Omaha and Lincoln, that would pick up all the rural
16 populations and filter into Omaha and Lincoln.

17 DR. MAZANEC: Maybe the more correct way to word
18 the recommendation is use the term provider, but I think
19 that we definitely wanted to put emphasis on the
20 beneficiary, also. But since the QI activities actually

1 involve the providers, maybe it's more correct to say --

2 DR. NEWHOUSE: And the incentives that are being
3 talked about go to providers, not to populations. Let me
4 suggest some wording. This is a separate point or a
5 separable point. Include those rural providers where there
6 is a pattern of care suggestive of lower quality, or
7 something of that nature, as opposed to just -- this is
8 again in the spirit of getting somewhat more targeting, and
9 also responding to the notion that we'd like them to use a
10 pattern of care rather than individual incidents.

11 MR. HACKBARTH: I like that addition, Joe. I
12 think that would be good. I wrestled with Bob's point,
13 which I think is very well taken. On the one hand, we're
14 saying there aren't many differences. Then on the other
15 hand we're saying devote more resources to rural. There is
16 some tension between those two positions.

17 The way I came down on that was if you followed
18 the logic to its conclusion, you could spend all of the
19 money in the urban areas and never have them go outside the
20 most urbanized areas. I don't think that that would be a

1 good outcome.

2 So I want to tilt it a little bit in favor of the
3 rurals and have some reward for PROs to focus on particular
4 clinical problems where there's some evidence of a potential
5 problem. I like Joe's wording.

6 DR. WILENSKY: Let me make two suggestions, one
7 procedural in a minute, and a second comment. In discussing
8 the quality issues, there seems to be a flavor that underuse
9 is the only quality problem and that inappropriate use and
10 overuse are equally problematic. And while we may not have
11 anything to offer on that work of Mark Chassen and others,
12 documenting the kinds of problems, overuse of antibiotics,
13 et cetera, it seems to send a very bad flavor in my mind,
14 that this is the only thing that we worry about as a quality
15 problem, underuse of services.

16 It's clearly not consistent with what we've done
17 elsewhere, other volumes, last year's treatment of quality
18 in a MedPAC report.

19 Why don't we turn specifically to recommendation
20 one and then recommendation two, so we can make some

1 modifications?

2 The issue, as I understand it, is that under the
3 current contracting requirements in the PROs, there is a
4 disincentive to include rural providers because of the
5 weighting issue. And so it strikes me that if we want to
6 see a greater likelihood that rural providers will be
7 included as targets, that we're going to have to do
8 something like this recommendation, or we ought to expect
9 that that won't happen.

10 Now there are two types of changes we can
11 consider. I found that a pretty innocuous recommendation,
12 but we can target it more. We can indicate either in the
13 recommendation, or we can indicate it in the paragraph that
14 follows the recommendation that we think it needs to be
15 targeted to providers and clinical settings where there's
16 some indication of clinical problems. I don't know that we
17 necessary have to put that in the recommendation.

18 I read the point of this recommendation is absent
19 some change we set up a system where we ought to expect PROs
20 will target where they get the biggest bang for their buck,

1 and that is in the urban areas with the higher
2 concentration. So this is to say, again, appropriately not
3 included here, that we don't want this at the expense of
4 consideration of a focus on minority issues.

5 But it struck me as either we make a
6 recommendation of this nature or we ought to assume that
7 there won't continue to be not much focus on the rural areas
8 by the activities of the PRO. Rural providers. It ought to
9 be rural providers in there.

10 DR. BRAUN: I liked the recommendation also.
11 Although it's obvious, I wonder if we shouldn't add assure
12 provision of adequate resources because it will be more
13 expensive and perhaps that needs to be said up front.

14 DR. WILENSKY: At the immediate time, that really
15 goes after the second recommendation, which has to do with
16 the frequency. It isn't necessarily on this recommendation
17 that it's more expensive. This is really just saying if you
18 include a factor which will re-weight the groups that they
19 consider in deciding which of the group to sample.

20 So I think you could do this without having more

1 resources, but our second recommendation, which reiterates
2 we want to see facilities surveyed once every three years,
3 requires an adequate resource base. So I'd rather, we can
4 either do that as a recommendation or in the discussion that
5 follows.

6 DR. BRAUN: So it's assumed that here the reason
7 they haven't done it is because of numbers?

8 DR. WILENSKY: No, it was assumed because of how
9 they're going to be judged. The judging, in terms of what
10 they are directed to do, encourages them to look to the
11 places where they'll get the most bang for their buck.

12 DR. BRAUN: The most bang for the buck but that's
13 why I'm wondering, they don't need more bucks if they're not
14 going to get more bang.

15 DR. WILENSKY: It's really a question of going
16 where you get the greatest concentration. The greater
17 concentration is in the urban areas. So I think you can
18 bring up the rural into the relevant pot by making this
19 recommendation, but not necessarily have more done. I think
20 the more done follows our second recommendation.

1 DR. ROWE: The way to do this would be not in a
2 recommendation, but to try to say to the PROs that if you
3 have a rural community within your jurisdiction, then in
4 some proportionate way we want your resources spent on that,
5 10 percent of them, 15 percent of them, 20 percent, whatever
6 it is. That would be the way to do it, rather than on the
7 number of doctors that you've reached or number of patients
8 that have been influenced.

9 DR. WILENSKY: Again, I think what we are seeing
10 here is an attempt to include it in a direct way into the
11 pot of providers that they have to review, to make this an
12 explicit group within the group that they have to review. I
13 think this does this in a very general way.

14 Now, there is a big difference between requiring
15 and encourage. I personally think if we're serious, then we
16 ought to say this has to be one of the groups that require
17 is appropriate. We can obviously use words encourage, but
18 the problem is that under contractual language, it's laid
19 out so that it pushes PROs in a particular definition. And
20 if we want to change that probability, then we have to

1 include a different listing within that, and we ought to
2 acknowledge that this will require, when they come up for
3 the next contract review, the language will be written
4 differently.

5 What I'd like you to do now, in terms of moving
6 this along, is we can either do a vote now on this, or if
7 you have specifics of an alternative wording that you'd like
8 to suggest, rather than this language, put that up so we can
9 do a vote and move on.

10 DR. LOOP: To include rural providers and then
11 take out in the groups that they consider. Say include
12 rural providers in carrying out their quality improvement
13 activities.

14 MS. RAPHAEL: I just wanted to step back for a
15 moment and make sure that the recommendations that we're
16 putting forth here, in fact, address the issues that we've
17 raised. I'm just worried that this is a fairly innocuous
18 recommendation in the sense that we identify the gap between
19 what care people should receive and what they are receiving.
20 And we also noted that people who reside in remote rural

1 areas and go to low volume hospitals tend to have poorer
2 outcomes.

3 I'm wondering if what we're recommending here,
4 even if we put in the word require, will end up in five to
5 10 years in making any headway in addressing those issues.

6 DR. WILENSKY: I think it's a fair comment. The
7 question is -- I want to know whether we can get to, with
8 the modifications that Floyd just raised, whether people can
9 be comfortable and take a vote on this recommendation. If
10 you want to have a follow-on recommendation that deals with
11 that issue, I don't know if we're ready to do that now. I
12 think it's a fair point, but I'm really trying to push us to
13 vote yea or nay, although I think you made good changes.

14 MR. SMITH: I guess I'd be comfortable voting for
15 this recommendation on the grounds that it doesn't mean very
16 much, but if it means something it seems to me we ought to
17 be very cautious about saying that with a lot of evidence
18 that some 30 percent of beneficiaries don't get adequate
19 care, that we want to divert a fixed pot of resources to the
20 lowest volume part of that overall inadequate performance.

1 If we wanted to add more resources because we felt
2 the differences really were driven by ruralness rather than,
3 as Carol suggests and I think as all of us had wondered,
4 whether it's driven by low volume. Maybe we ought to say
5 it's never going to make any sense for the PROs to devote
6 their resources to very small, very isolated rural
7 hospitals. Therefore, we need to devote some quality
8 improvement resources to it, and the Secretary should find
9 and provide some.

10 But we shouldn't say it makes sense to divert
11 resources from places where there's a potential big bang for
12 the buck to places where there isn't. That seems goofy.

13 DR. REISCHAUER: There's an equity argument that
14 everybody should have an option of getting --

15 DR. WILENSKY: Of getting reviewed.

16 MR. SMITH: I agree with you, Bob. But then that
17 argues for more resources.

18 DR. NEWHOUSE: That argument is stronger, though,
19 if there's an evidence of problems in the rural areas. But
20 there hasn't been much demonstration of that, is the

1 problem.

2 DR. WILENSKY: We don't know that.

3 DR. NEWHOUSE: But from what we present, this
4 doesn't follow.

5 MR. SMITH: It doesn't follow that we've got a
6 problem that says we ought to take resources from high
7 density areas and move them to low density areas. Because
8 the evidence is we have the same problem in both areas. And
9 the resources ought to be employed, Bob, it seems to me,
10 efficiently and the equity problem doesn't loom as large.

11 DR. REISCHAUER: The real issue here is, if you
12 spend a buck how much improvement times number of people can
13 you get in each of these areas? Not sort of the level at
14 which they're at right now. We don't know anything about
15 that topic, which is the marginal impact of another dollar
16 spent in rural versus urban areas.

17 MR. HACKBARTH: But we're looking at this as
18 though the only quality improvement resources come through
19 the PRO process. To me, part of the issue is that the urban
20 institutions have many more resources as their disposal than

1 the rural institutions do. They've got much larger
2 administrative structures, different staffing.

3 If PROs don't do it, there's a chance in the urban
4 areas that somebody else will. In these small rural
5 institutions, if there isn't some government encouragement
6 and support, it probably will not happen.

7 That's why I think, despite the efficiency
8 argument, there is a legitimate public policy purpose served
9 by saying we don't think the PROs' scope of work should be
10 skewed solely to urban hospitals.

11 MR. SMITH: But doesn't the relatively modest
12 difference even between the most rural areas and
13 metropolitan areas suggest that whatever is going on that's
14 useful in urban areas or inappropriately or insufficiently
15 useful is also going on even in urban influence code nine?

16 MR. HACKBARTH: No, I don't think that follows,
17 given what I've experienced and how things happen across the
18 health care system. I think the transfer of best practices,
19 if you will, is actually quite limited. So I wouldn't infer
20 that from the growth similarity in the patterns.

1 DR. NELSON: I'm not arguing again the use of the
2 word encourage. My earlier comments stand on that.

3 But I'm more concerned about the way the PROs are
4 currently doing their scope of work. In the HCQIP, Mary, am
5 I not correct that the Health Care Quality Improvement
6 Program is population based? That it's not looking at
7 providers, it's looking at the percentage of patients with
8 atrial fibrillation that receive anticoagulants.

9 DR. MAZANEC: Right.

10 DR. NELSON: If a PRO is going to study the
11 immunization rates on the elderly people, they're population
12 studies that -- I may be wrong, but I have the sense that
13 more of the quality improvement activities of PROs now is
14 focused on the population rather than just individual
15 providers.

16 If we are ignoring that reality in changing the
17 wording that you have here, I think we ought to be aware
18 that we are ignoring that reality.

19 DR. NEWHOUSE: Isn't that the incentive that
20 drives the PROs toward the urban areas?

1 DR. WILENSKY: The question is going to be, should
2 it be populations and providers?

3 DR. NELSON: I'm saying that I believe the word
4 populations is appropriate in here. I don't care if you add
5 the word providers.

6 It seems to me that this other argument that was
7 going on about urban versus rural is encompassed in draft
8 recommendation two for the point that was made that there
9 are other kinds of quality assurance capabilities in
10 licensing and conditions of participation and accreditation
11 that go beyond just what the PROs are doing.

12 I think our recommendation with respect to the
13 PROs ought to be consistent with the direction that the PROs
14 have been taking in their quality improvement activities.

15 DR. LOOP: I agree, and I think we have to have a
16 practical implication here. Are we diverting resources for
17 something that can't really be changed?

18 If you're looking at volume, volume relates to the
19 number of doctors the socioeconomic status of the patients,
20 the insurance, the distance, and the PRO can't really change

1 that. So I'm a little worried about this recommendation and
2 how it contributes to regulatory burden, also.

3 DR. WILENSKY: Let me just respond to that issue.
4 I think to the extent that we later get into questions about
5 whether or not there's some procedures that do better with
6 high volume care, for whatever sets of reasons that is the
7 case, to the extent that you had PRO QI activities focusing
8 on rural populations and rural providers, it might help
9 focus -- if that were the case -- either trying to change
10 the behavior of the providers or trying to change the
11 location of some kinds of procedures in terms of where they
12 were more likely to be provided.

13 So I think the answer is that while there are some
14 aspects that are not likely to be changed, how you respond
15 to a quality if you find a problem isn't necessarily tied in
16 to not being able to change the setting in which it's
17 located because it may mean be that it would be to try to
18 make it a different differentiation in terms of where
19 certain services are provided than may otherwise occur.

20 So that will be equally appropriate as an outcome

1 to the extent that it appeared that was the better way to
2 try to respond if there were patterns of care that seemed
3 appropriate by looking at rural populations and providers.

4 DR. WAKEFIELD: Just a couple of comments. I
5 think at least in part, related to the volume issue, the
6 volume is a proxy for other things. Maybe we do or don't
7 have a very good handle on what that proxy reflects. But it
8 might reflect things like a group of staff who work more
9 effectively together, and that can be part of a QI
10 initiative.

11 So yes, volume is important but I'd say we should
12 be stepping back and taking a look at what component parts
13 are associated with that high volume good outcome
14 relationship. And say that QI initiatives can be directed
15 at those component parts potentially.

16 Secondly, I'd say that to the extent that rural
17 hospitals rely on survey and certification, we rely to
18 ensure that beneficiaries have quality care. And they rely
19 more on survey and cert at the state level, as opposed to
20 JCAHO. To what extent does survey and cert processes

1 embrace QI? I think they're primarily QA. I don't think
2 they're QI. So we cannot look to the states in a consistent
3 fashion that I know of to pick up on QI efforts.

4 And the third issue that I guess I'd make is we
5 even say in our document, on page five, yes, we've got some
6 comparable delivery of ambulatory care services, but we've
7 got some differences in clinical outcomes related to some of
8 those services. So some of it is availability or use rates,
9 and some of it is what happens to that patient in terms of
10 patient outcomes? So I guess I'd just reinforce the
11 importance of this particular objective.

12 The last point I will make --

13 DR. WILENSKY: You're arguing in favor of the
14 recommendation.

15 DR. WAKEFIELD: I'm arguing in favor and I'll give
16 one more reason why I'm arguing in favor.

17 Right now I'm working with Don Berwick's IHI group
18 to try and outreach QI to rural hospitals. I can't begin to
19 tell you the difficult circumstances we're dealing with with
20 those rural hospitals across the country just to look at

1 some very basic QI initiatives. It is not easy out there.
2 I think a little bit of help on the front end would not
3 hurt.

4 So yes, I'm arguing for it, with Floyd's language.

5 DR. WILENSKY: I think you're really reiterating
6 Glenn's point, that there are a lot fewer QI activities
7 likely to go on in rural areas. This would basically
8 enforce some set.

9 I'm going to call for a vote on this.

10 DR. NEWHOUSE: Where did we leave the targeting
11 language?

12 DR. WILENSKY: Let me tell you as I understand,
13 what I'm going to ask for is the first vote and we can do a
14 separate vote if we want. To modify draft recommendation
15 one to include rural providers and populations. I think
16 there was an argument to have both words in there.

17 And to delete the phrase in the groups that they
18 consider. So just to include rural providers and
19 populations in carrying out their quality improvement. Am I
20 characterizing your language change?

1 DR. LOOP: Yes.

2 DR. WILENSKY: All right. In the first instance
3 we can do a required, although except for Alan I haven't
4 gotten, my sense is that most of you are comfortable with
5 required rather than encourage. I think encourage doesn't
6 really do anything, to be honest. I think either require it
7 or we can have a discussion and don't have a recommendation.

8 That's a correct characterization, in terms of
9 what to vote on?

10 All those in favor saying aye.

11 No?

12 Not voting?

13 Now on to the second.

14 DR. NEWHOUSE: But what about the targeting.

15 DR. WILENSKY: We can do two things on the
16 targeting. One is that we can have a discussion in the
17 paragraph that follows the recommendation. Or the second is
18 that we can have a second recommendation.

19 My recommendation is that we have the discussion
20 in the paragraph, but I don't feel strongly. I'd be glad to

1 listen if people have a recommendation to offer.

2 DR. NEWHOUSE: I'm kind of responding to the -- I
3 don't think I feel strongly, but I'm responding to the
4 motion that it's kind of uniform across where rural/urban
5 doesn't distinguish much. It seems to me that the right
6 answer to that then is to look for where the problems are,
7 and that rural/urban isn't the right dimension to focus on.

8 DR. WILENSKY: But presumably that's true at the
9 urban. As it now stands --

10 DR. NEWHOUSE: Maybe there should be a second
11 recommendation then, for that reason.

12 DR. ROSS: I'm voting for text, but we'd be happy
13 to explain as much within that, below the first
14 recommendation, that says rural is an all-encompassing term
15 and then just emphasize the diversity underneath.

16 DR. NEWHOUSE: I guess I still have a problem,
17 which is, I think, David's problem, also. That this
18 recommendation emphasizes rural but the hard evidence in the
19 text doesn't really lead you to this recommendation.

20 DR. REISCHAUER: How are we defining the problem,

1 the 2 percent difference between urban and rural or the
2 difference between 70 percent and 100 percent?

3 DR. NEWHOUSE: That's the issue.

4 DR. REISCHAUER: I'd be very worried about
5 something like this if I was then told that a third of the
6 resources or 40 percent of the resources were going to be
7 taken up evaluating rural facilities.

8 MR. SMITH: But, Bob, I think that's what you just
9 voted for. You didn't vote for 30 percent, but --

10 DR. REISCHAUER: No, I voted for something about
11 considering. It didn't say anything you said.

12 MR. SMITH: No, we voted to urge the Secretary to
13 require that a fixed pot of resources be split differently
14 to focus more on rural areas.

15 DR. WILENSKY: In the first place, we're about to
16 vote on something that requires the Secretary --

17 DR. NEWHOUSE: No, I'm still on one.

18 DR. WILENSKY: Let me go to Glenn. If there is a
19 specific recommendation that you want to make with regard to
20 a second recommendation, why don't you at least try to

1 either give a sense to Murray or we can come back tomorrow
2 morning to vote on it.

3 DR. NEWHOUSE: I want to propose -- this would
4 actually be quite a radical change, but to include those
5 rural and urban providers where there is a pattern of care
6 suggestive of lower quality, as recommendation one. I just
7 think that follows better from the numbers we present in the
8 chapter.

9 DR. ROWE: And I think it's more consistent with
10 Bob's concern about spending the money where you're going to
11 get the bang for the buck.

12 DR. WAKEFIELD: Joe, do we know now -- and I
13 haven't looked at this for quite a while, and only
14 superficially. Do we know now what drives PROs, in terms of
15 their selection of different topic areas? So for example,
16 do they choose their focus, diabetes management or CHF,
17 based on numbers in a population affected? Or because
18 there's a trend line that shows poor quality care in that
19 area?

20 DR. NEWHOUSE: Doesn't HCFA chose that set of

1 domains in their contract?

2 DR. WAKEFIELD: Yes, but I think you've got like
3 five or six general areas that they speak to.

4 MS. NEWPORT: I'd say that, Joe, before we go to
5 that type of explicit language, I would be comfortable
6 saying that I understand the scope of work and the
7 iterations of the scope over time to say that you have to --
8 to me, just as a gut check for me, is it strikes me as a
9 little different, quite a bit different than the scope and
10 the aim and the way the program has evolved over time.

11 I could be terribly wrong on that, but I think we
12 should confirm, at least, that we understand what level of
13 change we're driving within the purpose of the
14 organizations.

15 DR. WILENSKY: I agree. I think if we want to
16 make a statement like that, the most that we ought to do is
17 to consider what that language would look like, have
18 somebody have a discussion with HCFA this afternoon, to make
19 sure we understand the implications of that recommendation.
20 We may have to revisit it because that may be potentially

1 changing much more than we're understand that we changed.

2 What we're trying to do at this level is to
3 include as an explicit criteria, of one of what we regard as
4 many, the consideration of rural populations, which because
5 of the wording that is now in there, by their nature are
6 unlikely to make it up into a factor of consideration.
7 Without indicating the weighting or suggesting precisely how
8 to do that. But to have that as one factor in consideration
9 of the selection.

10 So I don't believe that while it is conceivable
11 you could have the problem that David raised, I don't think
12 anything that we've suggested in any way assures that that
13 will happen. That this is one of the factors under
14 consideration in the selection of populations or providers
15 for review.

16 But I'm more than willing to consider a reworking
17 or that addition if we're sure we understand how that would
18 affect the scope of work.

19 DR. NEWHOUSE: Maybe we could find out from HCFA
20 and come back to this.

1 MR. SMITH: Perhaps we should put it off to later
2 in the afternoon. But Gail, it seems to me the clear
3 meaning of required to include is required to include, not
4 take account of this one factor among many.

5 DR. WILENSKY: No. Right now, because of the way
6 it is set up, they are likely to be included and I think
7 that it does require them to be included. But there are a
8 number of areas that are required for inclusion, in terms of
9 choosing the populations and the providers for focus. So I
10 think the notion that you had suggested, in terms of the
11 redirection of resources, there will be some redirection of
12 resources. Whether it's substantial redirection of
13 resources I think is not clear from language that we've
14 suggested here.

15 MR. HACKBARTH: I'm going to repeat myself but
16 I'll go ahead. Practically speaking, this sort of
17 recommendation doesn't provide a whole lot of direction.

18 DR. WILENSKY: I agree.

19 MR. HACKBARTH: It is a symbolic statement as much
20 as it is a substantive statement because you could meet the

1 requirement of this require by putting \$1 in and say okay,
2 we included \$1 for PRO activity to rural areas.

3 DR. REISCHAUER: They don't have to do that, they
4 just have to consider.

5 DR. NEWHOUSE: We took out consider.

6 DR. WILENSKY: We took out that phrase.

7 MR. HACKBARTH: But it doesn't say anything about
8 resource levels, nor do I think it should. I don't think
9 our responsibility, our role, is to micromanage that
10 process.

11 I do think that there is information beyond the
12 similarity and the overall use rates. That is information
13 in the chapter, which is that the administrative resources
14 available for quality activities in rural hospitals are
15 dramatically less than in urban institutions.

16 Given that fact, I think it is appropriate for
17 public policy to say we are going to take some of the
18 resources that we have available and make sure that they are
19 provided in support of quality in rural hospitals. I do not
20 see any inconsistency in that.

1 MR. DeBUSK: In fact, aren't we back to the
2 statement I made to you earlier, Mary? What does this
3 really mean?

4 DR. WILENSKY: This recommendation stands as
5 written and we'll reconsider whether we want to add the
6 phrase that Joe has suggested. I think it is a level of
7 detail that may have more ramifications than we're prepared
8 to make this year. It goes to a much more general statement
9 about quality.

10 I think, having just thought a bit about it, this
11 is really a chapter on rural. It's appropriate if we
12 believe that QI dollars are not likely to go particularly to
13 rural areas because of the targeting that now exists and
14 that this would change that, the general issue that it looks
15 as though -- to the extent the information is correct --
16 that seniors might be getting appropriate or best practices
17 72 or 73 percent of the time, and the difference is not
18 great between urban and rural areas is a focus that we ought
19 to have in our next quality chapter in MedPAC and not
20 really, I think, raised here particularly.

1 Again, in the discussion I think it is appropriate
2 to make the point that the differences between urban and
3 rural are probably less troublesome than the low, absolute
4 level that we're finding for seniors in general, and that
5 will be taken up again in the future.

6 I think that, as I've thought about it, is
7 probably a better way to handle the issue that you're
8 raising but let's go try to find out how much impact that
9 would have on the scope of work and we can revisit it in the
10 morning.

11 MR. HACKBARTH: What if, as an alternative to
12 this, we were to say -- what was your language?

13 MR. SMITH: Glenn and I were just talking. If we
14 were to pick up on Glenn's point and say that because rural
15 hospitals are much less likely to have quality improvement
16 resources available to them, the Secretary should figure out
17 a way or design a way or develop a way to see that those
18 resources are provided. Rather than the current
19 recommendation which, I agree Gail, it doesn't say 30
20 percent or \$1. But it does suggest that we ought to shift

1 resources in a way which I think we would all agree, if it
2 happened in any meaningful sense, would be inefficient.

3 Our point here, and it seems to me is Glenn's,
4 that these resources are less likely, for a whole variety of
5 reasons, size, cost, the incentives built into the PRO
6 contracts, to get to rural hospitals. And that's a problem.
7 Let's fix that problem.

8 But why would we want to do it by diverting
9 resources inefficiently?

10 MR. HACKBARTH: To say that, the reason is to
11 supplement the limited resources available, makes the
12 recommendation much more focused, as to the problem it's
13 solving. It's not trying to solve a problem of grossly
14 different appropriateness of care. We don't have the data
15 to support that as a problem.

16 The problem is that these institutions, with their
17 very lean administrative structures and budgets, if there's
18 no federal support it's probably not going to happen.

19 DR. NEWHOUSE: I like the general thrust of that,
20 but it seems to me we again there's a big diversity among

1 rural hospitals. I mean, some of the big rural hospitals
2 could be a major teaching hospital and could be fine. Now
3 maybe that's an item for the text.

4 DR. WILENSKY: How do you want to change the
5 recommendation of this language specifically?

6 MR. HACKBARTH: Maybe I could write something out,
7 with Mary's help.

8 DR. WILENSKY: All right, we'll take this up after
9 lunch, if you want to consider alternative language. Let's
10 go to draft recommendation two. Any concern about
11 reiterating this recommendation from last year, that we have
12 at least one-third of each facility type surveyed annually.

13 DR. NEWHOUSE: Do we want to put in the
14 recommendation that we're reiterating it?

15 DR. ROSS: The recommendation will be written that
16 the Congress should.

17 DR. WILENSKY: And in the paragraph it will
18 indicate this is a reiteration of our recommendation from
19 last year.

20 MR. HACKBARTH: I support the recommendation. I

1 guess if I worked in a rural hospital though, I might think
2 of this as a mixed blessing.

3 DR. WILENSKY: Always.

4 MR. HACKBARTH: To me that just reinforces my
5 previous point, that these folks have very limited
6 resources. Going through the survey and cert process takes
7 a lot of time and effort, and I don't think it necessarily
8 is a quality improvement activity. I would like to see some
9 resources devoted to the quality improvement, just not the
10 survey and cert process. And the PRO vehicle is the way to
11 do that.

12 DR. WAKEFIELD: I just have the same concern.
13 Personally, I like reiterating the recommendation. But it
14 absolutely does raise the question about who pays the bill
15 and where do those responsibilities fall to? How much to
16 Congress? How much to the state level? How much to the
17 institutions themselves, et cetera.

18 I think without a doubt, costs are going to have
19 to be somewhat dramatic because, as we discovered, many of
20 these institutions aren't being reviewed for years on end.

1 So that, I think, needs to be addressed but it will not come
2 without a cost. And the question is where is that cost
3 coming from?

4 DR. WILENSKY: Take a vote on reiterating the
5 recommendation?

6 DR. BRAUN: Do we need to add that phrase, to
7 assure provision of adequate resources? I mean, it's
8 obvious.

9 DR. WILENSKY: I would think that that ought to be
10 in the text. I think obviously if you're going to do more
11 survey and certification, it is going to have an increased
12 cost.

13 All those in favor, raise your hands?

14 All those opposed?

15 All those not voting?

16 Okay, Glenn, if you can give some rewording, we'll
17 raise this immediately when we reconvene. We'll reconvene
18 at 1:30.

19 [Whereupon, at 12:49 p.m., the meeting was
20 recessed, to reconvene at 1:30 p.m., this same day.]